Department of Children's Services

JUVENILE JUSTICE, DIVISION OF COMMUNITY SERVICES

MECHANICAL RESTRAINT REPORT

Region: _____ Date Restraints Used: _____

Youth Restrained: _____

Staff Member Using Restraint:_____ Title: _____

Detailed Statement as to Why Mechanical Restraints Were Necessary: _____

_____

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Supervisor Consulted and Giving Approval: _____

Medical Treatment Necessary ☐ Yes ☐ No

_____ _____

Signature of Staff Member Using Restraints Supervisor's Signature

_____ _____

Date Date

Original: Case File

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